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Fatal and Near Fatal Delays in Surgery

By Neil John Maclean, M.D., M.R.C.S. (Eng)., F.A.C.S., F.R.C.S. (Can.)

The causes of delay in obtaining surgical relief are numerous. That these delays may be reduced to a greater extent is the object of this article. It is not to be expected that every phase of the subject will be discussed here as much must be left to the imagination. A delay in certain surgical emergencies may be as fatal as an error in surgical technique. The reasons for delay will be considered from two aspects—first when the responsibility is solely the patients and finally where the physician may have failed to apprehend a serious condition and therefore treatment has been unnecessarily delayed.

The Patient

Patients are so frequently to blame for delay in seeking advice. This is not the doctor's responsibility. However, as a profession we should instruct the public individually, and through Public Health services collectively. This, of course, is being done, but the question is "could not more be done?"

When a patient presents himself for an annual check-up and a clear bill of health is about to be given, would it not be wise to instruct him at this time regarding the danger signals of the more urgent conditions, in which the time element is so important, and advise him accordingly? I have known patients to delay when an illness occurred after a recent check-up, because they thought it improbable anything serious could develop so soon. Unless an examination is very exhaustive—and this is prohibitive for the average patient — serious trouble can be missed. A wealthy patient can afford everything that medical science can give and yet may be stricken with an emergency, such as an acute appendicitis or internal strangulation of the bowel, the day after a most complete examination. Again, an early malignancy may have begun in some internal organ and be at a stage when the most scientific examination could not reveal it.

As some serious conditions in their earlier and therefore more curable phase are without pain, patients frequently delay seeking advice even though they may have seen or felt a lump or swelling. They commonly say "because it did not trouble me I did not think it serious". They act on the old adage of "don't trouble trouble, etc." Generally speaking I feel this neglect is largely due to a lack of education. It is my hope that in the near future some attempt will be made to teach in the schools, especially in the higher grades, some of the simpler fundamentals of the commoner diseases. Take the following case for example: A female patient, age 52, consulted me regarding a lump in the right breast fifteen years ago. She first felt the swelling thirteen months previously but as it gave no trouble (being absolutely painless) she paid no further attention to it until its size caused her to seek advice. The mass was by that time the size of a grapefruit, firm, smooth, skin not adherent nor puckered, and moved on the chest wall, though not freely. The axillary glands were not palpable. An X-ray plate of the chest showed the lungs to be negative.

A diagnosis of sarcoma of the breast was made with the second possibility of it being a simple fibroma. Immediate operation was advised. A total mastectomy was done, going wide of the tumor but not disturbing the axilla (fibro-sarcoma does not metastisize by the lymphatics). The pathological report was fibro-sarcoma. The patient was well for ten years when a lump occurred in the scar which proved to be a recurrence.

Thirteen months harboring the most malignant tumor which was amenable and most accessible to surgery! Had the patient **reported at once**, I feel absolutely justified in saying (in retrospect) there would have been no recurrence.

Again, so many persons are afraid that something serious may be wrong and do not want to be told the truth—an atavistic instinct passed along from the ostrich.

For some non-essential personal reason a patient procrastinates the taking of treatment and thereby loses the most essential thing of all, health or even life itself.

A patient felt a lump in the right breast. She knew full well that she should consult a doctor but did not because in three months she was due to be retired from her occupation on pension. She delayed those three months and thus lost the most precious opportunity in all her life. She was then operated on and the most radical and scientific operation for this condition known to surgery was done. At this time the axillary glands though not large showed cancer cells microscopically. For five years the patient was in perfect health. Then vague pains developed in the region of the liver. Do I need to tell you more? Death occurred within a year.

We do not know the exact time metastasis in malignant disease occurs. In research laboratories experimenters have found cancer cells in the lymph nodes thirty-three days after cancer had been implanted in mice. I have personally observed a cancer on the back of the hand that began as a tiny wart six weeks before it was removed widely. Two weeks later the axillary glands were removed "en masse" and they showed microscopic areas of cancer cells. The degree of malignancy varies in different types but it can be said that if there is a delay of three months before a breast cancer is removed the patient will die sooner or later from metastases which occurred during that period of delay.

Then, too, for economic reasons some have missed the golden opportunity of time. One of the saddest cases in my experience was a woman who had concealed for **eight months** a cancer in the breast. When she consulted me she had metastases in her spine. Although of intelligence above the average, she had not consulted a doctor or sought advice from anyone. Her reasons were (following a period of unemployment) her husband had joined the Army. Also, she had an only son attending school and felt she must look after him. Now, when she could have gone to hospital for treatment it was too late and furthermore, she would not go into a public ward. It was a case of "Pride and Poverty". She gradually failed, suffering the usual agony of the hopeless progressing incurable cancer case.

The Doctor's Responsibility

When the patient finally arrives at the consulting room of the doctor, or the doctor visits the patient, then his responsibility definitely begins.

Medical men know well that "the advantage of time and place once lost can never be regained". Yet the application of this truth is often allowed to fall short by indecision and inaction.

The general practitioner and the surgeon must be constantly on guard in diagnosing acute abdominal conditions and be prepared for quick action. If the practitioner is not himself an operating surgeon he should shift the responsibility to one who is.

Two groups of cases must be considered.

First: A group of abdominal catastrophies that brooks no delay. No delay does not mean the short delay necessary for making an exact diagnosis.

Second: A group in which delay may not only be safe but may even be advantageous to the patient.

The differentiation as to which group the case belongs is obvious. The first group is the one that concerns us most in this discussion. Acute appendicitis, intestinal obstruction, strangulation, perforation of gastric and duodenal ulcer, ruptured intestine (traumatic), ruptured internal organ (pathological or traumatic) and twisted pedical, a group roughly classed under the caption of "the acute abdomen".

The second group, while the symptoms may be equally alarming, includes such cases as those where an emergency operation is definitely not indicated or may be debatable. The important question is, will delay increase the danger of final recovery or complicate the case in the event of a later operation being necessary. Among this second group are renal and uretral calculi, gall stones, colic and cholecystitis, pancreatitis, diverticulitis, spastic colon, mucous colitis (simulating intestinal obstruction thus leading to unnecessary emergency operation, as does also lead-colic), salpingitis and various other diseases. However, the seriousness of a wrong diagnosis in these two groups needs no stressing.

Doctors today are academically so well trained and with the practical hospital experience which each student receives he is well qualified to make a working diagnosis. The man in active practice is usually on the alert and by frequenting available clinics, study groups, refresher courses and medical meetings, can invariably read the "signs at the cross roads." However, disease is often so insidious in onset or strikes with so little warning that the most sagacious can be caught off guard. Error when it occurs is usually one of diagnosis. It is seldom that a doctor is really careless but occasionally one sees a case which has been considered too casually, that has not been examined with the seriousness that the symptoms demanded and hence valuable time has been lost in establishing proper treatment.

This applies in medicine as well as in surgery. A few cases of acute abdominal conditions and cancer will suffice to bear out these remarks.

The Acute Abdomen

"When desperate ills demand a speedy cure
Distrust is cowardice and prudence folly."
—Samuel Johnson.

Appendicitis is the commonest of all acute abdominal emergencies.

I think it is universally agreed that acute appendicitis always demands an emergency operation with as little delay as possible. There are only two exceptions to this rule; one, an attack which is positively subsiding when first seen and the other when the attack has gone on to the formation of a mass or is past the third or fourth day—the case of which Richardson of Boston said "was too late for an early and to early for a successful late operation."

If a patient has recovered from one attack of acute appendicitis he should not run the risk of a second. My first case of acute appendicitis died in the second attack which occurred two years after the first—it was then taught to advise an interval operation if the patient recovered from the second attack. It has since been estimated that eighty percent of severe cases occur in the second attack. I know a man whose son (about fifteen years of age) has had three attacks of acute appendicitis with vomiting and who has repeatedly refused to allow him to be operated upon. It is like harboring a viper in the abdomen.

It is important to diagnose acute appendicitis quickly and correctly and not just "Acute Abdomen" because of the type of incision to be use. It has been proven beyond peradventure that a McBurney incision is not only followed by fewer complications such as burst abdomen, incisional hernia, multiple abscesses, but has a definitely lower mortality rate. A Battle incision is for one who needs elbow room, a paramedian incision is for exploration which has no place in operating for acute appendicitis. The symptom of vomiting in acute appendicitis has not been, in my observation, properly evaluated as to its significance. If vomiting is pronounced the appendix is invariably obstructed and tense with pus. The other symptoms, pain and local tenderness, may be surprisingly mild and the temperature and pulse normal. Time and again I have seen delay in diagnosing this type of appendicitis even until rupture has occurred. Such a case I saw with a confrere some years ago. The patient was a young man in his prime and in perfect health up to the day he was seen by the doctor. The patient was wakened with pain across the lower abdomen about 5 a.m. The doctor asked me to see him at 8 o'clock the same evening and apologised by saying "He is not very sick, I'm ashamed to call it appendicitis." Truly it seemed like an extremely mild attack of appendicitis, the pain being slight, the tenderness very slight on deep pressure, temperature and pulse normal. However, when I asked him if he had vomited he said "Yes, I've been vomiting all day." Not that either the doctor or I considered the gravity of the case at the time, but because the young man was going North into the Hinterland, in fact was on his way, we advised him to have his appendix removed, considering he might not have as good a chance should it recur later. At the operation the appendix was found distended to the size of a ring finger and had to be removed with the greatest care for fear it would burst. It was tense with bluish-green pus. That day we both learned a most important lesson, the significance of vomiting in acute appendicitis.

Another case, a facsimile of the foregoing, except that digital rectal examination revealed the end of a tender sausage-like mass lying to the right of the rectum. Like the other case, the patient had been taken ill in the early morning with pain, nausea and vomiting. The pain and local tenderness not being severe and other symptoms negligible, the attending doctor procrastinated till evening. A diagnosis of pelvic appendicitis was made and immediate operation advised. The appendix was found down in the pelvis and had to be hooked up with the index finger, care being taken not to rupture it. Like the preceding case the lumen of the appendix was tense with pus.

Pelvic appendicitis is difficult to diagnose and in the female the difficulties are increased. One patient was seen by an internist on a Transcontinental train with an attack of low abdominal pain and vomiting. The doctor had her admitted to hospital and on consultation with a gynecologist a diagnosis of salpingo-opheritis was made. Ten days later I saw her when a considerable mass had formed. An abscess had to be drained and after some weeks she was able to continue her journey home. Reviewing the case a diagnosis of acute pelvic appendicitis should have been made. Had she had her appendix removed as an emergency she would have been saved much time in hospital and a subsequent operation for incisional hernia, the result of abscess drainage. I have seen three fatal cases of acute pelvic appendicitis in the female where earlier diagnosis would have saved

their lives. I have already emphasized the importance of early diagnosis in acute appendicitis and operation without delay. We should in any case of "acute abdomen" be able to say, is this a case for an emergency operation or is it not?

Ruptured Intestine Without External Wound

If a patient has had a blow on the abdomen and no external wound to be seen, board-like regidity of the abdominal wall indicates serious internal injury. In eliciting this symptom it is most important to differentiate between the setting of the abdominal muscles which occurs immediately the abdomen is touched and the board-like rigidity which one can appreciate is there even before the abdomen is touched. If only injured muscle is present it will resent being touched and will go into spasms the moment it is touched, whereas if the intestine is ruptured the abdominal wall is continuously set and rigid. Le Jars and other French writers make the distinction quite clear between the degrees of défense musculaire and rigidité du bois. The size, weight and force of the missile must also be considered in making a diagnosis of a ruptured viscus. I have seen in all five cases of ruptured intestine without external wound. One was so late in arriving in hospital and had such gross laceration of the small intestine that he died after operation. Two had immediate operation and both recovered. Two had delayed operations and made stormy recoveries. One of these refused operation till his parents arrived. There were three perforations in the ileum. The other was in hospital and although the record showed the abdomen was rigid on admission, no action was taken for fifteen hours, though two perforations were found and peritonitis had already developed. Distension following operation was extreme but relief by a Miller-Abbott tube was, I think, what saved his life.

Cancer

Notwithstanding the education given to the public in recent years regarding the necessity of early recognition and treatment of cancer, advanced cases continue to appear.

I shall limit my remarks to cancer in three regions, the tongue, lip and colon, including the rectum, because early cancer in these locations is highly curable. Cancer located in the tongue and lip is not only slow in metastasizing but is where it can be seen and diagnosed early, yet many cases come late. When metastases do occur they are held up by the lympth nodes in the submaxillary and submental regions for a long time, in fact in theory at least no one should die of cancer of the tongue or lip. This is in strong contrast to cancer in the floor of the mouth which is highly malignant and most fatal.

Still there are many causes for delay. For instance, a patient, male aged 45, consulted a doctor for a small sore on his tongue. The doctor very properly took a W.R. Test which proved to be three plus positive. Four months later when I first saw him a biopsy showed it to be cancer. How can one justify such loss of valuable time? However, I got a fair result from surgery and radium, in that he was alive and well ten years later. A hemiglossectomy with radium placed in the wound was first done. Three weeks later block dissection of the lymph glands on the same side of the neck and again radium placed in the wound. Again two years following the last operation he had a small nodule removed from the centre of the scar and radium used. This was done in New York. A year later I removed another small nodule from the scar. The four months delay was a great trouble and very costly to this man. Compare this with another case of cancer of the tongue, seen early and treated with radon seeds implanted in the growth, who was alive and well twelve years after.

One case of cancer of the lip illustrates the result of delay. The patient, male, age 40, had cancer of lower lip treated with radium in 1924. Radium then was in the experimental stage. I first saw the patient in 1929 when he had a recurrance. The lip was excised. In 1933 an enlarged gland appeared on the mandible near the mental foramen on the right side. It was adherent to the jaw and in removal required resection of a part of the mandible. Although the patient is apparently cured of cancer after 20 years from the commencement of treatment, he has recently had to undergo two bone-grafting operations to repair the defect in the mandible. What trouble and suffering this patient might have been saved by adequate treatment in the beginning?

Cancer of the colon and rectum is very amenable to surgical treatment. It is, however, difficult to diagnose because the early symptoms are vague and indefinite. Then, too, because the general practitioner does not frequently meet this condition among the cases seen by him in his daily practice. One doctor told me he saw only two cases in twenty years of a large general practice. Therefore cancer of the large bowel is seldom diagnosed in its earlier phase, which is regrettable because of its curability. About seventy percent of cases of cancer of the large bowel can be reached and felt with the examining finger. This requires to be taught and retaught. A recent patient consulted her doctor because of a persistent diarrhoea. Without a physical examination of any kind he prescribed a diet of buttermilk. When seen by me three months later a mass could be felt high in the rectum. An abdomino-perineal resection was done but she died of metastases within two years. Had three months not been lost I am sure this patient would have had many years of good health.

The colon clinically and surgically is divided into a right and a left and each have their diagnostic problems which often account for delay in diagnosis and therefore treatment. A patient came from a western city complaining of right-sided abdominal pain and a change in the bowel habit. She was treated for some time and finally taken to a hospital where a serious attempt was made by her doctor to arrive at a diagnosis. Because of uncertainty in coming to a conclusion he sent her to me. Her general appearance was very good except for pallor but she had not lost weight. Her blood, however, showed the hemaglobin and red blood cells to be down fifty percent. There was a vague fullness in the right side of the abdomen opposite the umbilicus. A diagnosis of cancer of the ascending colon was made and a hemicolectomy was done. This patient lived ten years. I believe had a little quicker action been taken she would have had a cure.

Cancer of the left colon is seldom diagnosed before the bowel becomes obstructed. One case I saw and operated upon who had cancer of the splenic-colon was in hospital over two weeks being investigated. Acute intestinal obstruction developed necessitating a blind caecostomy before direct operation for removal of the growth could be done, causing further delay. Notwithstanding, this patient is alive and well over ten years.

There is no room for delay in the successful treatment of malignant disease.

To my readers: I once heard a doctor say "I am not interested in cases, I want principles" but is it not from cases and post mortems that we deduce our principles? This article was written for the younger men and women who are anxious to learn but should any others read it, no harm can follow.

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An attack of psoriasis is a certificate of good health.
—Jonathan Hutchinson.

Notes on Common Infectious Diseases

By E. F. Taylor, M.D., King George Hospital

In the civilian world the scarcity of nurses, the closing of the smaller hospitals with the consequent over-crowding of the larger and the never-ceasing cry against absenteeism force the average physician to pause and decide how much of the elaborate medical set-up can be discarded with safety. Already he has bowed to the loss of the special nurse, dainty meals and a long convalescence for the majority of his patients and has adapted himself to the untrained helper, rationed food, and the demand for a quick return of his patient to work.

With the above conditions prevailing many patients with communicable diseases will have to be cared for at home. In the care of these, where should the physician be strict? where lenient? how much of the old treatment can he disregard? how much of the new accept?

German Measles

There is a rumour going round that one doctor solved the difficulty, when his nurse contracted this disease, by having her apply a thicker layer of powder and remain at work.

Scabies

The tendency seems to be on the increase to send this patient to an infectious hospital, filling beds which should be reserved for a more serious illness.

If seen early, the lesions should respond to Scabanca treatment. The tub-bath recommended, though desirable, cannot always be obtained and a cleansing sponge will have to do. The Scabanca is applied, preferably with a brush, on the body as directed; i.e., an application while the body is still wet followed by a second application five minutes later. No bath is given the next morning, nor again that night when a third application is given. One treatment is sufficient in the majority of cases.

The odor of sulphur and the burdensome washings of underwear and linen are eliminated and the patient unless in direct contact with others may remain at work.

Chicken Pox

There is no specific prevention or treatment. Soaking in a warm bath for twenty minutes once or twice a day relieves the irritation and shortens the healing period. Nembutal or other sedation may be necessary to insure a night's sleep in the initial stage. Should a pock become infected, a glycerine and Mag. Sulph. compress may be applied instead of the time-consuming fomentation, and with equally good results. One does not have to wait till the scabs have been shed before releasing from quarantine. Once the pocks are dry the patient is considered free from infection.

Mumps

Again there is no specific prevention or treatment. The patient should be kept in bed for a week, then bathroom exercise for three or four days, and released from quarantine at the end of the second week.

The most frequent complication is orchitis, which occurs in approximately sixteen percent of the cases and usually within the first ten days of the disease. Mild sedatives such as Frossts 222 (one tablet every four hours) will alleviate the pain or morphine may be necessary. Support and applications of heat and cold may be applied, but the patient complains that they bring little comfort and discards both.

Occasionally headache, nausea and vomiting, pain across the epigastric region, and an elevated temperature occurs instead of the orchitis. Spinal drainage, or injection of insulin have brought no relief and sedatives little. Fortunately, the symptoms only last about forty-eight hours.

A few cases have been seen where the intense swelling of the parotids and sublinguals have produced oedema over the upper sternum, caused, it is believed, from pressure on the lymphatics. One has only to relieve the anxiety of the patient by assuring him that he is not going to suffocate to death.

The sufferers from Mumps are returned to work a day or two after their release from quarantine with the warning that complications may still occur and should be immediately reported to the attending physician.

Measles

The Sulpha drugs have no noticeable effect on the disease itself. This was to be expected as the infection is due to a virus. One must still rely on symptomatic treatment.

As for the complications of otitis media, mastoiditis, and pneumonia: they appear to be little influenced by the drug. Sulphathiazole is given when pneumonia develops and, though the pneumonia is not alleviated, it is thought that pleurisy with effusion is modified if not wholly prevented. When effusion occurs, sufficient fluid is aspirated to determine the causative organism and then the appropriate Sulpha drug prescribed. Rarely is it found necessary to aspirate or do a rib-resection. If such is needed the patient should be in hospital (which need not be an infectious one, as explained later).

Convalescent measles serum from passive immunity is not easily obtained these days. The physician who wishes to protect a contact may have to collect and inject whole blood. The amount of blood withdrawn from the donor depends on how recently he has had Measles. Four centimeters of blood would be a sufficient amount from one who has had Measles within a month; and twenty to thirty centimeters from an adult who gives a history of having Measles in childhood.

The blood withdrawn should immediately be injected subcutaneously or intramuscularly.

The success of this procedure depends on the number of antibodies in the donor's blood and how early it is injected after exposure. If injected within the first four days of exposure, Measles will be prevented if injected on the fifth and sixth day a modified attack occurs, which is thought to give permanent immunity. After the sixth day the injection of convalescent or adult blood has no effect on the course of the disease.

The quarantine period has been gradually reduced over a period of years from two weeks to one week, due to crowded conditions in the hospital. It is known from experience that the period of infectivity is very short once the rash is well developed, the patient being considered safe to be moved with others after three or four days even with catarrhal discharges from nose or ear present. Operative cases (if they can be carried over this time) may be admitted to a general hospital.

Erysipelas

Unless the patient is delirious, he can be cared for at home. In hospital, the treatment for an adult is ten centimeters of Neoprontosil injected intramuscularly, and followed for the next forty-eight hours with ten to fifteen grains of Sulphonilamide every

four hours. If the Sulphonilamide alone is used, the initial dose should be larger.

Patients suffering from Erysipelas should receive sufficient sleep. Morphine is the most satisfactory sedative and will only be needed for one or two nights. Recovery is rapid, and the average patient ready for discharge at the end of a week.

Diphtheria

With this disease one still follows the old adage "make haste slowly". Adequate antitoxin and rest must be maintained and the patient released from quarantine on three cultures negative for K.L.B. Contacts should also be released by negative cultures and (if able to live away from home) return to work.

The consensus of opinion is that the untrained attendant looking after the invalid should receive an immunizing dose of diphtheria antitoxin, unless she has received three injections of toxoid.

One does not need to urge that the toxoid injections should be given at an early age. Here is one preventive that gives such excellent results—ninety-five percent plus—that the physician enthusiastically recommends it to the parents for their babies.

Scarlet Fever

The incidence of Scarlet Fever has been high this Winter. Some people have had to be nursed at home though the long quarantine period of four weeks must have caused considerable inconvenience.

The contacts to Scarlet Fever may be released if they can give a history of having had the disease and can find accommodation elsewhere. It is preferable for the attendant looking after the patient, particularly if untrained, to have had Scarlet Fever. Protection by giving an immunizing dose of scarlet fever antitoxin can be secured, but one hesitates to advise this because due to the long period of infectivity in this disease the immunization to be effective must be repeated with the risk of producing anaphylaxis. If one is heroic enough to attempt it, two thousand units should be given each week.

In treating the patient, scarlet fever antitoxin should be used as early as possible but not before a diagnosis is made. Nine thousand units is sufficient for practically all cases, mild or severe. The temperature, sore throat, and rash, tend to return to normal within twenty-four hours, unless complications are already present.

Since the use of the antitoxin, complications have been reduced by over seventy-five percent; but the antitoxin must be given early to produce this result. The only exception to this reduction being nephritis, the incidence of which remains the same.

Serum sickness, once the bugbear of physician and patient alike, formerly occurred in forty-eight percent of the cases, but this percentage is now reduced to less than one percent—a statement the victims in this minority group find hard to believe.

The scarlet fever streptococci are referred to as Sulfa resistant, the drug having no appreciable effect on the disease or complications, such as acute otitis media and mastoiditis. However, septicaemia and meningitis accompanying or following the mastoiditis respond rapidly to Sulphonilamide. This may be due to a different type of streptococci or to a higher concentration of the drug in the spinal fluid and blood than can be obtained in the middle ear or mastoid cells.

Arthritis is still treated with salicylates. The other complications, such as pneumonia and pleurisy, occur so rarely that no conclusion can be drawn at the present as to their response to either the antitoxin or the Sulfa drugs.

The release from quarantine is still unsatisfactory. Four weeks' isolation and free from catarrhal discharges are the requirements.

Carcinoma Breasts

By M. R. MacCharles, M.D., C.M., F.R.C.S. (Edin. and Can.)

Education of the public about cancer, is yielding striking results. Women who discover a lump in the breast now, present themselves to the physician within a day or a week, instead of waiting for one or two years.

Immediate diagnosis is essential because this offers the only practical method of increasing the percentage of cures.

In proceeding to make a diagnosis, various factors will be considered.

History

In breast tumors the history is of minor importance. Two points are worth remembering.

1. A woman whose close female relatives (Mother, Sister, Aunt, Cousin) have had cancer of the breast, is six times as likely to have a malignant breast tumor, as the average woman.

2. A history of rapid increase in size of the tumor is very significant.

Age

In doubtful cases the age is the most important single factor. Practically all tumors of the breast, developing before 35 are innocent, and those developing after the menopause are all malignant. In the intervening decade, both types appear, and the diagnosis must be made on other grounds.

Physical Examination

The details of the general examination will be omitted. The local examination will commence with inspection. Adequate exposure is fundamental. The opposite breast is usually normal, but may vary in size or nipple level. Only a recent change in either is significant. All contours of the breast should be curved, and a flat area in a curve suggests underlying malignancy.

Palpation

Palpation should be carried out with the flat hand. not finger-tips. The consistency, of the tumor may be soft, firm hard or stony hard. Cancer may be of any consistency, but the stony hard tumor is always cancerous. Cancer of the breast is often tender on palpation and may be exquisitely tender. A breast tumor may be fixed to surrounding breast tissue, to underlying muscles or chest wall or to the skin over the tumor. Fixation in breast tissue is not easy to determine and therefore of little value. Fixation to underlying muscle or chest wall means gross disease. Fixation of tumor to overlying skin in the absence of a scar is diagnostic of malignancy. Invasion of the skin may be miminal and only determined by careful examination after moving skin back and forth or lifting the skin and observing a dimple over the tumor.

Site

It is a striking fact that 90% of all cancers of the breast occur in the upper half, and only 10% in the lower half. In the upper half 60% are found in the outer quadrant and 30% in the inner quadrant. Cancer may also arise from the extreme periphery of the breast, and occasionally in the axillary tail of Spence.

When the local examination of the breast is complete, and you have diagnosed or suspect malignancy, the next procedure is to determine the extent of the disease. Breast tumors spread by direct extension and by lymphatic and venous drainage. Direct extension is determined during examination of the breast. Lymphatic drainage of the breast is centrifugal, the tumor being represented by the hub of a wheel, and the radiating lymphatics by the spokes. The largest spokes goes to the axilla, possibly because 60% of all cancers grow in the quadrant next to it. A smaller channel goes direct to supraclavicular glands, others through intercostal spaces into mediastinum, another subeutaneously in front of the sternum to the opposite breast, another along the rectus sheath through the umbilicus to the liver, and finally along the lymphatic channels accompanying intercostal nerves toward the spine.

Venous spread conveys metastasis to the general circulation, where many are destroyed but some survive and multiply in the lungs or vertebrae, pelvic bones or various other sites.

To determine the extent of lymphatic spread, one palpates the axilla, supraclavicular areas, opposite breast, opposite axilla, and the liver area. An X-Ray film of the chest may show (but rarely does) mediastinal involvement.

Spread of the disease by the blood-stream may be demonstrated by the chest film. Involvement of bone is evidenced by pain persistent and increasing, and X-Ray changes in the bone are late.

With all this information one is now able to classify the case according to the extent or stage of the disease. The Steinthal classification is commonly used.

Stage 1. Tumor localized, freely movable, no evidence of regional or distant metastases.

Stage 2. Tumor localized, freely movable metastases in axilla (not fixed), no distant metastases (includes supraclavicular).

Stage 3. Tumor fixed or movable. Regional metastases with fixation. Distant metastases.

Stage 1 and Stage 2 are classed as operable cases and Stage 3 inoperable.

Treatment

In many cases the diagnosis of the original tumor may be in doubt after all the above examinations. This can only occur in cases without metastases, and without positive local findings, in other words, in early cases. Under these circumstances one proceeds to do a biopsy (providing there are no general contra-indications to operation). This is one site where a biopsy (if proven malignant) must be followed immediately by operation. So before doing a biopsy the patient is prepared for radical operation.

In those cases in which the diagnosis is definite on clinical grounds alone, the question of treatment becomes more complicated.

The modern surgical treatment of cancer of the breast dates back over 50 years, and a vast amount of information is available in this field.

X-Ray Therapy has been used for about half that time, and is a supplementary method only.

Radium Therapy holds a very minor place.

Opinion on the correct application of these three methods is far from unanimous. The Surgeons are not proud of their results to date. In Stage 1 about 70% are alive and well at the end of 5 years, while in Stage 2 only 18% have survived and are free from disease after 5 years. This is an extremely significant fact emphasizing the value of early diagnosis (4 times the chance of cure). In Stage 3 only 4% are alive and of course show evidence of disease.

There is fairly general agreement that Stage 1 cases should be treated by immediate operation only, and complete agreement that Stage 3 cases should be treated by Radiation only. In Stage 2 cases, the controversy persists, Surgery only, Radiation only, pre-operative radiation, post-operative radiation. Practically it is often difficult to get these patients to undergo a prolonged course of X-Ray Therapy followed 4-8 weeks later by operation. In a relatively small group of cases where pre-operative radiation was given, local recurrence did not take place.

Operation

The radical removal of breast, sufficient quantity of skin, underlying fascia, pectoral muscles and axillary contents offers a better chance of cure than any conservative operation. An operation of less extent should not be contemplated unless for palliative reasons.

Summary

1. An immediate diagnosis of single breast tumor in women over 35 is mandatory.

2. Diagnosis is more difficult but treatment more effective when patients present themselves very early.

3. The only practical way to improve results is more frequent early diagnosis.

4. Do biopsy if necessary, but be prepared to proceed with radical operation if necessary.

Hospital Luncheon Program Reports

St. Boniface Hospital

April 27th.

Chronic Mastitis—Dr. R. O. Burrell

Dr. Burrell spoke about the newer concepts of chronic mastitis. This condition is a chronic endocrine disorder due to hyperoestrinism. There are three types easily distinguished clinically. The first is mastodynia, the second is adenosis and the third is cystic disease. Dr. Burrell discussed each type and dwelt upon treatment by progesterone and B. complex. He stressed the pre-malignant nature of adenosis.

Obstructive Jaundice

Dr. A. C. Abbott reported a case of obstructive jaundice in which a growth was found at the ampulla of Vater. The interesting point was the fact that the growth was a benign papilloma. Benign growths on this site are exceedingly rare.

Gastric Carcinoma—Dr. I. Pearlman

Two years ago a woman of 60 was operated upon for carcinoma of the stomach. It was regarded as inoperable and pieces removed for microscopic examination (including glands) showed the growth to be adenocarcinoma. For nearly two years she had been steadily declining until, two months ago, she was jaundiced, oedematous and apparently moribund. Strangely enough when she was presented by Dr. Pearlman she appeared to be well, had no swelling or jaundice and was able to move freely. She had been given no special treatment. Placebos were the only preparations given. This case illustrates the basis of more than one cancer cure and shows how dangerous it is to accept a post hoc as necessarily a propter hoc cure.

May, 1944.

Psychosis Following Pregnancy—Dr. A. Kobrinsky

Dr. Kobrinsky related the histories of four women who had become psychotic during the puerperium. In severity the cases varied from mild to most severe. Dr. Pincock, who was present and took part in the discussion, said that he had seen recently an unusually large number of such cases. The mental state of a pregnant woman is as important as her physical condition. The breakdown may come with alarming suddenness and then the patient must be under continual observation for, if left to herself, she may take her own life or that of her child. The type of insanity varies, the clinical syndrome and picture depending upon the prepsychotic personality. Manic-depressive psychosis usually appears 3 to 12 days after delivery and carries with it a not unfavorable prognosis. Schizophrenic manifestations ordinarily appear after the patient has left hospital, though irritability and unreasonable behaviour may earlier indicate the likely end of this insidious beginning. The prognosis is poor. J.C.H.

Bone Tumor—Dr. P. H. McNulty

Dr. McNulty showed a series of x-ray films taken over a number of years. The first was taken after an accident in which the patient fractured her right femur. The x-ray revealed a cystic expansion of the bone. Since then the patient had received much x-ray treatment and the latest film showed a healed process. Meanwhile, symptoms suggestive of herpes led to x-ray of the spine and the discovery of a collapsed veretbra while other bones included in the film showed multiple small lesions. Drs. Funk, Murray, Prendergast and Wheeler took part in the discussion, which was chiefly concerned with the nature of the process. One important fact to emerge was that a disturbance of the blood calcium—phosphorous ratio (normal in this case) was not always present in parathyroid tumours and that the multiple lesions in this case might be due to such tumour. Drs. Wheeler and Burrell believed that the lesions were metastatic from a small, inactive and, so far, undiscovered neoplasm. J.C.H.

Winnipeg General Hospital

Sequelae of Spinal Anaesthesia

The following sequelae occur as recorded in literature following subarachnoid block: headache; paralysis of the following cranial nerves—6, 5, 7, 8 and 12; lesions of the cauda equina; reticulo-myelitis; loss of bladder tone; haemorrhage; aseptic meningitis and septic meningitis.

In reviewing the literature one finds that the use of spinal anaesthetic agents with more than one ingredient cause sequelae more often than the simple novocaine or provaine drug. Also a careful selection of cases will eliminate many sequelae. Patients suffering from chronic headache, any neurological or cerebro-spinal condition are not suitable subjects for subarachnoid block. Despite the most careful preoperative examination one will miss latent neurological disease. Such patients receiving spinal anaesthesia may or may not develop a complication. Prominent amongst such conditions is a latent brain tumour. Caution must be exercised in selecting spinal anaesthesia unless the patient is free from organic neurological signs. D.C.A.

Some Experience With Pulmonary Embolism
Dr. F. G. Allison

Dr. Allison gave a review of six cases of pulmonary embolism with a mortality of 16%. He first reviewed three medical cases; a case of coronary occlusion, a case of status asthmaticus, and a case

(Continued on Page 169)

Winnipeg Medical Society—Notice Board

P. H. McNULTY—*President* W. F. TISDALE—*Secretary*
A. M. GOODWIN—*Vice-Pres.* E. S. JAMES—*Treasurer*

At the last Executive meeting a document signed by a number of Internists was read in which they prayed the Society to admit them as a Section. Their prayer was granted. This organization was not for the purpose of the physicians meeting to indulge in scientific discussions, though that may come in time, but was a defense mechanism. At the moment the subject under consideration by the Manitoba Medical Service Association is fees. As it stands, the arrangement is to pay full fees when a patient is referred but if the patient should come directly the fee "shall be that paid to the general practitioner plus a premium of 15%." That is if the G.P. gets $3.00 we would get $3.45, a premium of 45 cents. A premium! Ha, Ha. I've seen better ones with a bar of soap. Meanwhile, the surgeons, in spots, based their fees on wishful thinking. This leads to a belief in the biblical prophecy which foretells "To him that hath shall be given and from him that hath not shall be taken away even that which he hath." There was a time when surgeons stood meekly by waiting permission from the physician to operate. Those were the golden days of medicine, just as these are the days of golden surgery.

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Your new President, ladies and gentlemen, is Dr. P. H. McNulty, President of the McNulty Clinic, 2nd Vice-President of the Manitoba Medical Association, well and favorably known to a wide circle as a man of many interests and great versatility. He is progressive as well as conservative, if you know what I mean. His wide knowledge of disease includes its manifestations in animals as well as humans. He has the appearance, and also some of the habits, of Mr. Churchill. All in all, the auguries are good for a successful year.

Elected to serve with him were: as Vice-President, Dr. A. M. Goodwin; as Secretary, Dr. W. F. Tisdale; as Treasurer, Dr. E. S. James; as Trustee, Dr. Anna Wilson. Her election went to prove the assertion that gentlemen prefer blondes.

Preliminary to the election was the reading of reports. The chairman of a long list of committees reported everything was in fine shape. The representatives of sections reported success on all fronts. The treasurer reported a bit of money in the till and a neat bundle of Bonds against the possible "rainy day."

After the reading of the reports and while the ballots were being counted, certificates of Life Membership were conferred and Dr. Strong gave his address.

Admitted to Life Membership were Dr. F. J. Hart, Dr. Ross Mitchell and Dr. H. W. Wadge. The little ritual, adopted three years ago, went smoothly and gave dignity to the occasion. The sponsors (Dr. Fred Young for Dr. Hart, Dr. J. A. Gunn for Drs. Mitchell and Wadge) recounted the claims of the candidates and they in turn replied fittingly.

Life Membership does not deprive one of any of the privileges he enjoyed as an ordinary member, it is not a preliminary to the retiring of a member and is definitely not a pre-mortem recognition. It is an expression of appreciation given to active members who, we hope, will continue to be active in the interests of the Society.

Dr. Strong spoke well upon the Supervision of Medical Practice. There was much reason in his sayings. He laid bare some of the ulcerous places in practice and gave his opinion how to get rid of the infection "which mining all within, corrupts unseen". As was to be expected, he spoke, as he always does, with courage, conviction and sincerity, and with many touches of humour which, incidentally, often removed the sting from a biting comment.

Here endeth the 31st session of the Winnipeg Medical Society and here endeth also the present series of Notice Boards. When you have read this latest communication we shall set the Board aside until September when, perhaps, you will again gather around it. Hope you will.

Continued from page 167

of a healthy woman put to bed in hospital for physical and mental rest. Two cases were following surgery; one was a gastric resection and the other followed a colostomy. The sixth case followed parturition.

Dr. Allison stressed watching for leg aches and painful dorsiflexion of legs. Pleuritic pain and stained sputum suggest pulmonary embolus, which may occasionally be confirmed by X-ray and sometimes by cardiograph.

A patient suspected of pulmonary embolism should have a hypodermic by the bedside containing Papaverine grs. one.

Dr. Allison discussed the use of Heparin and Dicoumarin. The use of Heparin costs around $12.00 per day and Dicoumarin takes some 48 hours before it becomes effective. The use of vitamin K to correct the over-effect of Dicoumarin has not been satisfactory but the new vitamin K, oxide in dosage of 400 mg. intravenously is reported to neutralize Dicoumarin in 18 hours.

It is necessary to have a daily prothombin time tested.

Dr. Allison recommended tying the femoral vein distal to the saphenous opening in both legs if Homen's sign of painful dorsiflexion is found, or if a minor embolism has occurred. The three reported cases who had veins tied off had no further emboli and suffered no inconvenience from this minor operation.

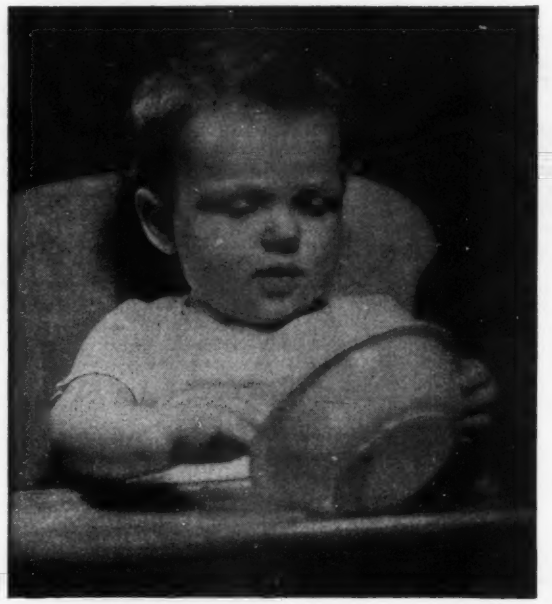
Those taking part in the discussion were: Drs. Burrell, Nicholson, Gunn, McQueen and Shubin.

Misericordia Hospital

Dr. R. Mitchell, Dr. D. Nicholson, Dr. B. Chown

The Rh factor was the topic of discussion at the May Clinical Luncheon at Misericordia Hospital. Dr. Ross Mitchell introduced it by giving the histories of three cases in which there were repeated abortions or speedy death of the new-born. In all cases the mothers were found to be Rh negative. The pathological background for these and similar unhappy occurrences were discussed by Doctors D. Nicholson and B. Chown.

The Rh factor is normally present in 85% of the population and these are referred to as Rh+. The remaining 15% are Rh—. In pregnancy an Rh— mother will receive from her Rh+ foetus specific agglutinogens against which her reticuloendothelial system will elaborate anti-Rh agglutinins. These, in turn, are transmitted to the foetus with resulting agglutination and haemolysis. The clinical result is erythroblastosis foetalis — icterus gravis, congenital hydops, and trythroblastic anemia. The first infant usually escapes because it may require more than one pregnancy to develop a sufficient degree of isoimmunisation to injure the foetus. The Rh factor is of significance in the matter of transfusions. A single transfusion of Rh+ blood is of no importance. Repeated transfusions in the case of a Rh— recipient, of Rh+ blood will, however, lead to the production of anti-Rh agglutinins and the agglutination of the donor's cells in the patient's vessels.



War Diets OF LITTLE HELP IN PEDIATRICS

WHETHER rationing is more or less liberal, the pediatrician as always has the problem of supplying sufficient vitamins A and D to his young patients. Vitamin D in particular must be supplied abundantly to insure adequate structural development and calcium-phosphorus metabolism.

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Editorial

The Manitoba Medical Service Association is very near to becoming an active affair. The contracts have been revised, discussed and re-revised, until now they appear to be free from flaws. Some matters still remain to be settled—chiefly the question of fees, but these are approaching settlement. Meanwhile, one gathers that there are some who are apprehensive lest the scheme contain points that are not to their liking. I have suggested to the committee that copies of the contracts be sent to each member of the Association and that a general meeting be called to consider them.

One might think that anxiety about fees is out of place and indicates a greater concern in what we get than in what we do or give. But we can never lose sight of the fact that the Dominion Scheme is going forward and that when it is in force we shall no longer be in a position to decide what any fee may be. It is important, therefore, that we should pay attention now to matters concerning our future livelihood.

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Manitoba Medical Service

After many vicissitudes Manitoba Medical Service may now be said to be fairly launched. Six additional medical men have recently been added to its Board of Trustees. Officers of the Board have been named, and Manitoba Hospital Service Association, the selling agent, will soon be offering to the public contracts for medical and surgical care on a prepayment basis.

It seems fitting to review the steps which have led to the creation of this medical service plan. In the troubled years of the depression the Executive Committee of the Manitoba Medical Association appointed a Committee of Sociology which later became the Committee of Economics. This committee was entrusted with oversight of Winnipeg Medical Unemployment Relief and of the Firefighters' Club. The creation of this latter club, composed of Winnipeg firefighters and their dependents, led to requests from other groups of employees to have medical care along similar lines. After much time and thought spent in study of medical service plans and of local conditions, the Committee of Sociology evolved a plan which was adopted by the Manitoba Medical Association and named Manitoba Medical Service.

The reasons which impelled the Committee of Sociology (Economics) to suggest, and the Manitoba Medical Association to approve, the formation of Manitoba Medical Service were these:

1. A desire to extend the benefits of medical service to a large and deserving group who were neither indigents nor wealthy.

2. To set up a non-profit scheme endorsed by organized medicine in the province and open to all members of the profession.

3. To benefit from the experience of setting up and running a voluntary prepayment, non-profit, scheme of medical service before the proposed national health insurance act should come into force.

Let us elaborate on these.

Under the existing set-up of the medical practice two groups receive adequate medical care, the rich and the very poor. Between these is the large group of small-wage earners, honest and independent, who do not wish charity and yet are unable to pay the cost of up-to-date medical care. The success of the Manitoba Hospital Service Association is proof that these people can and will set aside a modest amount at stated intervals in order to secure the benefits of hospital care when the need arises. It is but one small step forward to create a like scheme which will provide medical and surgical care. The Code of Ethics of the Canadian Medical Association opens with these words: "For the honorable physician the first consideration will always be the welfare of the sick." The primary duty of the medical profession as a unit of society is to keep up the health and physical well-being of the public. Anything, therefore, that the medical profession can do to extend the blessings of modern medical care to the people as a whole will lift up the profession and redound to its credit.

It is well known that several medical service plans are in operation in Winnipeg and have been operating for some years. These, however, are strictly limited as to participants and in some instances the profit motive enters. There is no choice of doctor and they are not open to the general profession. More than one commercial insurance company sells sickness and accident insurance and within the past year a well-known insurance company with headquarters in Winnipeg has entered this field. In medical circles elsewhere there is a widespread interest in non-profit plans for providing medical care. By October, 1942, there were eleven such plans operating in the United States in conjunction with approved Blue Cross Hospital Service plans, and there are several medical service plans in effect in Canada.

A plan such as Manitoba Medical Service enables men and women to seek medical advice when they need it and not when they feel they can afford it. How much better it is for all concerned for the rheumatic child to receive attention before his heart is crippled; for the inflamed appendix to be removed before general peritonitis has set in; for cancer to be recognized and treated before it has reached the hopeless stage!

It is agreed that many difficulties will be encountered in the first years of a national health insurance scheme. If the Manitoba Medical Association can set up a voluntary prepayment, non-profit medical service plan, operate it for a year or more before the national scheme comes into effect, and make it work, many of these difficulties will then be ironed out and the experience gained in operating the plan will be of great help to the public and to the medical profession.

It must be emphasized that Manitoba Medical Service, though a non-profit plan, must be run on strictly business principles if it is to succeed. Each practitioner taking part will have the benefit of no bad debts, but to make the scheme work he or she must co-operate wholly. Accounts must be rendered promptly. For the first year at least the scale of fees paid will be slightly lower than one obtains in a practice amongst the well-to-do, but to offset this there will be a greater volume of work because of the plan. The experience of the Firefighters' Club showed that many of the participants needed surgery. Before the creation of the club this was beyond their reach, but when a way was opened by which their needs could be met without additional expense they were quick to take advantage.

If each medical practitioner will consider himself a member of a co-operative scheme of mutual aid and work whole-heartedly to make it a success, Manitoba Medical Service will succeed and become a mighty instrument of good in this community.

R.B.M.

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The asthmatic should go supperless to bed.

—Lindsay.

Association Page

Apres Moi, Le Deluge or Bourbons Never Die

It is a historical fact that the revolution that swept Louis XVI to the guillotine had been rising for some 75 years. Each Bourbon felt secure amongst the privileged class. The famous remark "Apres Moi, le deluge" was made by Louis XV who, if we read history correctly, realized the plight of his empire but did nothing about it. Louis XVI inherited the Bourbon arrogance with an added load of sloth and stupidity. In May, 1879, the States General met in Versailles "because of the hunting." It is clear that the King and Queen meant to treat the fuss as a terrible bore, and to allow it to interfere with their social routine as little as possible. We find the meetings (States General) going on in salons that were not wanted, in orangeries and tennis courts, and so forth.

We have Bourbons in the medical profession today. There are unmistakable signs, naked and alarming that the public is not satisfied with medical practice. Let us point out some of these red flashes of danger:

(a) In the submissions made before the Social Security Committee in Ottawa in 1943 and 1944 many groups stated emphatically that the distribution of medical care to the public was not equal to scientific information of today.

(b) The Cultists, a vociferous and unwearying group who never cease to flay the medical union. This year we find that fees paid to one of the cults may be legitimately used as income tax deductions. It is easy to give the shoulders a typical Bourbon shrug but there is an important fact for medical men to consider.

(c) Another part of the picture lies in the selection and limitation of medical students to the physical resources of the medical school. A section of the public would allow anyone to enter medicine provided that they had the required academic standing. This might easily mean classes of 175 to 225 in Manitoba yearly.

Just why do these signs of public exasperation not register with the medical profession? Perhaps the following might be considered:

1. High Income Level of Doctors. With the limited number of doctors available for civilian use there is a high average income with a limited means of spending it. Add to these facts a war-weary and in some instances a neurotic group that turn to the profession for help from cares that threaten to overpower them. Louis XVI enjoyed his falcons while the peasants sharpened their scythes. Marie Antoinette enjoying the delightful shade of Versailles, listening to the cool spray of the innumerable fountains said to one of her courtiers "If the peasants haven't bread, give them cake."

2. Individualism. As a rule doctors plough a lone furrow. Collectively the Allies outnumbered Hitler in 1940, but as each nation took on "der fuhrer" singly they soon became a member of the third reich. If doctors continue to negotiate as individuals or in small groups with the government we shall soon find ourselves members of the civil service.

3. Privilege. In attaining a medical degree a doctor pursues a long arduous and expensive course. When the state grants him the privilege of medical practice when he graduates from the university, has he any special debt to society in return for the state aid to the medical school? There are people who believe that doctors have a moral obligation to the public after graduation.

4. Apathy. One of democracy's many faults lies in the fact that a high percentage of people rarely consider that they have a responsibility to their fellow man. In a totalitarian state these individuals have no choice but to do as they are told. In a democracy they never vote. In a questionnaire they are always too busy to reply. Medical apathy is as useful to the profession as adiposity is to a decompensated heart.

5. Membership — Today the Association has an enrolled membership of 80% of maximum. While under ordinary circumstances this might be considered good, in view of the suggested changes in medical practice, we look forward to the day when we can present a totally united front by claiming 100% membership in the Association. If you are one of the 20%, will you not correct the oversight?

There was a time in "the good old days" that a medical man could stand aloof from his fellows. The annual meeting of his association had a few business details worked in amongst a pleasant reunion of his confreres. At the annual dinner with much good food tucked under his belt, he left the gathering with the feeling "that God's in his Heaven, All's right with the world."

With the unmistakable signs of storms upon the medical horizon why do we engage in futile talk, internecine strife, "wait and see" tactics before putting our house in order? We might be compared to a noted King who was always on horseback but who never rode forward.

It has been said that the proposed Health Insurance Act arose largely from the fact that a section of the public believed that the profession had forgotten them.

Are we not as France during the early 30's? The workmen frittered away their time over never ending sit down strikes, sufficient government deputies would not combine to give France the stable government that she required. All this time Hitler was forging a sure and efficient instrument that swept away France as a world power within a few weeks. The moral to this tale is that the Ottawa mills are slowly and relentlessly grinding out some form of Health Insurance.

Will the many medical men who are now in His Majesty's Forces perhaps in 1960 gathered together to review the first year of state medical services drink a silent toast to the medical Bourbons of 1944?

D.C.A.

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Letters to the President

Dear Doctor Aikenhead:

In view of the fact that Manitoba Medical Service Association is expected to go into operation in June, 1944, the Membership of the Manitoba Medical Association should be made thoroughly familiar with all the advantages and disadvantages of the plan. As this represents a step that may have permanent and far-reaching consequences, a special meeting of the Manitoba Medical Association should be called to discuss the various provisions made in the bill and in the contracts that will be offered to the profession and to the public.

It seems strange that the Association plan has never been submitted to Mr. Hugh Wolfenden, actuarian retained by the Canadian Medical Association to advise it on Medical Economics, to Dr. Heagerty who has been studying health plans for the Dept. of Pensions and National Health for the Government of Canada, or to any trained economist.

Whereas the plan was sponsored originally by the Manitoba Medical Association to assist citizens in low income brackets, it now transpires that

EVERY citizen in Manitoba, irrespective of his means, can buy this insurance. One understands that the schedule of fees to be drawn up for this plan need not apply to persons with incomes over $3,000.00 per year. It becomes the responsibility of the medical practitioner to ascertain the income bracket of the individual patient so that an additional fee may be rendered to him if his financial circumstances permit.

It should be understood that those buying this service can make every demand on the medical profession, and their obligation is limited to the fee paid for the insurance irrespective of the volume of medical attention required. It is quite conceivable that the medical profession might be called upon to give twice the amount of service that the Association can afford to pay. In such cases the medical practitioner might receive less than his usual fee for the first 50% of the work, and must absorb the entire loss of the second 50% of services.

The sponsors of this plan agree that in the first years the fund will not be large enough to pay for the medical services that are likely to be required by the insured group, due to the fact that many elective procedures will be carried out on these patients. Many of these conditions have remained untreated for years, and under this scheme they will have to be treated. This is the first time in years when the average citizen is able to pay the regular fee for medical services he may require. The public is more health conscious than ever before, and it is the right time to educate the public to health requirements. However, with the profession depleted by the young men joining the forces, and the graduating classes being taken automatically into war services, with the result that the remaining medical men are being worked to the breaking point, it hardly seems the propitious time to be making additional demands upon them.

If this problem has been approached from the standpoint of determining what constitutes adequate scientific investigation and treatment of disease in an average group large enough to make the law of averages operate, there must be agreement on the proper compensation for such medical service. Basing one's calculation on the known average income of such a group, the proportion of the cost that can be properly charged against this group should be determined. Should this amount fall short of the estimated amount, then responsibility for the extra charge should be placed on the industry employing that group or on the provincial government, and not on the medical profession.

Over the past 25-30 years a steady inflation has occurred, largely due to a continually increasing government borrowing. Also, over this period, the purchasing value of the dollar has been reduced to 60-65%. Furthermore, the income tax now in force reduces its value still further. This income tax is not likely to be materially reduced after the war, if the grand schemes for full employment and social security ever materialize. This reduces the purchasing power of the dollar to well below 50% of that of 30 years ago. This fact should not be lost sight of in drawing up a schedule of fees.

In submitting these observations, I wish it to be understood that for a number of years I have been completely convinced of the wisdom of applying the principles of insurance to the problem of providing health and hospital service to the public. The above remarks are NOT a **criticism** of that principle. But if the mentioned points have been already carefully considered, I, as a member of the Manitoba Medical Association, would like to know the attitude of the Committee responsible for creating and setting in motion the Manitoba Service Association plan.

Yours truly,
P. H. T. THORLAKSON, M.D.

HITO Age 43 Occupation: President Greater East-Asia Co-prosperity Sphere, Inc.

Diagnosis.

Patient appears to be suffering from mental reactions following rabies.

Past History.

The illness was indirectly caused by his partnership in the Greater East-Asia Co-prosperity Sphere, Inc. The patient was allotted a territory in China. While in Shanghai in 1937 he was bitten by a rabid dragon.

The patient has not completely recovered from the shock; hydrophobia and other mental symptoms remain. The dragon is doing well.

Mental reactions simulate those of delirium tremens and he imagines attacks at various times by eagles (U.S.) and lions (Br.).

There is a definite mistrust of all those around him. The patient has a feeling of insecurity and apprehension. He feels that his partners in business have failed him. He is less inclined to travel, feeling that when he is away from home he is liable to be suddenly attacked. Sea voyages, he believes, are definitely dangerous.

Treatment.

To date treatment has been purely symptomatic, the patient is being persuaded to wind up his partnership and withdraw from the Greater East-Asia Co-prosperity Sphere, Inc. He is to lead a quiet life of retirement; frequent purges (Tojo) are recommended. The taking of oil and quinine is to cease and rubber to which an allergy exists is to be avoided.

Personal Notes and Social News

Capt. James Rosslyn Mitchell, R.C.A.M.C., only son of Dr. and Mrs. Ross Mitchell, was married on May 13th to Catherine Gertrude, third daughter of Mr. and Mrs. W. R. Clubb, of Winnipeg. Capt. and Mrs. Mitchell will reside in Eastern Canada.

♦

Major Norman Lewis Elvin, R.C.A.M.C., of Winnipeg, was recently made an officer of the Most Excellent Order of the British Empire.

♦

Dr. Donald Gordon Coghlin, son of Mr. and Mrs. J. D. Coghlin was married April 26th at Westminster United church to Isabelle, daughter of Mrs. Elizabeth Pease of Winnipeg.

♦

Dr. and Mrs. J. A. Porter are happy to announce the birth of a son (Thomas Angus) at St. Boniface Hospital.

♦

Capt. V. J. McKenty, son of the late Dr. Donald McKenty was recently decorated with the Military Cross which he won for valor in the Italian campaign.

♦

Dr. George McNeill of Treherne, Man., youngest son of Mr. and Mrs. McNeill of Winnipeg, was married on April 22nd at Treherne, to Marie Frances Neal, daughter of Mr. and Mrs. C. Metcalfe.

♦

Dr. and Mrs. D. Braunstein, Rossburn, Man., take pleasure in announcing the birth of a daughter on April 21st, 1944, at Russell hospital.

♦

Lieut.-Col. Roy W. Richardson, R.C.A.M.C. overseas, was recently promoted to the rank of Colonel, military authorities announced.

♦

Dr. D. J. Brandson was honored by the University of Manitoba, when at the annual convocation, held May 12th, the honorary degree of Doctor of Laws was bestowed upon him.

♦

Dr. and Mrs. R. B. W. Wengel are receiving congratulations on the birth of a daughter (Aldis Elin Anna) at the Winnipeg General Hospital on May 16th, 1944.

♦

Dr. F. A. Macneil left for the East to attend the Canadian Medical Convention. He will proceed to New York City to attend the meeting of the American Broncho-Esophagological Association on June 6th, returning to Winnipeg about June 15th.

♦

Dr. John Bruce Moir, R.C.A.M.C., second son of Mr. and Mrs. H. H. Moir of Winnipeg, was married May 6th to Helen Adelaide, younger daughter of Mr. and Mrs. H. L. Huyck, of Melfort, Sask.

♦

Major G. H. Ryan has been named by the Army to serve on the staff of a joint treatment centre in the special fields of plastic surgery, neuro-surgery and orthopedic surgery to be established in the Deer Lodge Military Hospital.

♦

Captain and Mrs. C. F. Benoit are happy to announce the birth of a son (Clair Arthur Douglas) on May 14th, 1944, at St. Boniface Hospital.

Dr. Joseph Gonty, formerly of Belleview, Man., is now located in Winnipeg.

♦

Dr. and Mrs. G. Normandeau of Lorette, Man., are rejoicing over the birth of a son (Raymond Bernard) on May 21st, 1944, at the St. Boniface Hospital.

♦

Dr. and Mrs. Alvin B. Watson of Winnipeg and Vancouver, announce the birth of a son (Donald Alvin) on May 10th, 1944, at the Winnipeg General Hospital.

♦

When Father
went to college,
Ambitions he had three,
no one studied harder
to earn one of these degrees:
M.D.—Medical Doctor
D.D.—Doctor of Divinity
LL.D.—Legal Law Doctor.

When Junior
went to college,
He was happy as could be,
on all the following subjects
He procured his majority:
M.D.—Merzy Doates
D.D.—Doezy Doates
LL.D.—Little Lambzy Divey.

♦

Obituary

Dr. Robert Brodie Anderson died in the Winnipeg General Hospital April 29. Born at Almonte, Ont., 69 years ago, he received his education in Winnipeg, graduating from Manitoba Medical College in 1903. After a short term of practice at Moose Jaw he went to Edinburgh for past graduate work. On his return he went on a tour of inspection for the Dominion Government investigating the conditions of the Indians in the reserves on Lake Winnipeg, and later was associated in practice in Winnipeg with Dr. C. J. Jamieson and Dr. A. R. Winram. Returning to Edinburgh he received the F.R.C.S. (Edin.) degree, and became a Fellow of the Edinburgh Obstetrical Society. After some months of study in Dublin he received the degree D.P.H. from Trinity College and the L.M. from Rotunda Hospital. From 1910 he followed his practice in Winnipeg until joining up for service in 1914-18.

For many years he was an elder of Old Kildonan Presbyterian Church. He is survived by his widow, a daughter, Patricia, who is in charge of the operating rooms in Winnipeg General Hospital, and three sons in the Royal Canadian Air Force.

Big-hearted, generous and kindly, Brodie Anderson had many friends both in and out of the profession.

♦

Anti Meningococcus Serum Off the List

The Department of Health and Public Welfare of the Province of Manitoba, on the recommendation of the Board of Health, has taken ANTI MENINGOCOCCUS SERUM off the list of biologics supplied free to physicians in the Province of Manitoba. This was done because the sulphonamides have proven of equal or greater value in the treatment of meningococcal meningitis.

Pertussis vaccine, which has only been put up in the one person size packages, will be available in the six person size package very shortly.

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1944 Mar. 26 to Apr. 22	1944 Feb. 27 to Mar. 25	1943 Mar. 28 to Apr. 24	1943 Feb. 28 to Mar. 27	TOTALS Jan. 1 to Apr. 22,'44	TOTALS Jan. 1 to Apr. 24,'43
Anterior Poliomyelitis	—	1	—	1	1	7
Chickenpox	178	299	132	115	1044	680
Diphtheria	9	14	25	28	43	108
Diphtheria Carriers	1	4	3	3	12	11
Dysentery—Amoebic	—	—	1	1	—	2
Dysentery—Bacillary	—	—	—	1	—	3
Erysipelas	8	7	3	8	30	22
Encephalitis	—	—	—	1	2	2
Influenza	5	26	40	103	96	294
Measles	1163	783	448	283	388	990
Measles—German	39	66	15	3	162	28
Meningococcal Meningitis	2	1	8	4	8	18
Mumps	227	350	508	548	1113	2096
Ophthalmia Neonatorum	—	—	—	—	—	—
Pneumonia—Lobar	8	9	20	31	56	87
Puerperal Fever	1	—	—	—	1	1
Scarlet Fever	308	344	148	140	1199	441
Septic Sore Throat	1	3	5	5	9	19
Smallpox	—	—	—	—	—	—
Tetanus	—	—	—	—	—	—
Trachoma	—	—	—	—	—	2
Tuberculosis	34	53	41	77	157	183
Typhoid Fever	—	1	3	1	1	9
Typhoid Paratyphoid	—	—	—	—	—	—
Typhoid Carriers	—	—	1	—	—	1
Undulant Fever	—	—	—	—	1	2
Whooping Cough	15	37	309	227	102	837
Gonorrhoea	144	93	141	118	535	591
Syphilis	55	55	37	43	200	164
Meningococcal Meningitis Carriers	—	—	—	—	—	6

DISEASE	Manitoba *738,000	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,300 Minnesota	*641,935 North Dakota
*Approximate Populations.					
Anterior Poliomyelitis	—	—	—	2	—
Meningococcal Meningitis	2	10	1	23	3
Chickenpox	178	1270	105	—	—
Diphtheria	9	—	3	16	3
Dysentery—Amoebic	—	—	—	9	—
Bacillary	—	—	—	1	—
Erysipelas	8	2	—	—	4
Influenza	5	85	13	6	80
Measles	1163	2794	264	4394	426
German Measles	39	382	185	—	1
Mumps	227	905	50	—	3
Puerperal Fever	1	—	—	—	—
Scarlet Fever	303	960	96	769	159
Septic Sore Throat	1	3	—	—	—
Trachoma	—	—	—	—	4
Tuberculosis	34	225	25	—	16
Typhoid Fever	—	10	4	1	—
Typhoid Para-Typhoid	—	1	1	—	—
Undulant Fever	—	4	—	14	—
Whooping Cough	15	164	23	77	18
Diphtheria Carriers	1	—	1	—	—
Gonorrhoea	144	589	—	—	17
Syphilis	55	506	—	—	14

DEATHS FROM COMMUNICABLE DISEASES

March, 1944

URBAN—Cancer 43, Pneumonia Lobar 12, Pneumonia (other forms) 6, Tuberculosis 5, Influenza 4, Syphilis 2, Mycoses 2, Lethargic encephalitis 1, Measles 1, Puerperal septicaemia 1, Cerebrospinal meningitis 1, Hodgkin's disease 1, Septic sore throat 1. Other deaths under one year 15. Other deaths over one year 201. Stillbirths 18. Total 314.

RURAL — Cancer 23, Pneumonia (other forms) 9, Tuberculosis 7, Pneumonia Lobar 6, Influenza 5, Whooping Cough 3, German Measles 2, Syphilis 1. Other deaths under one year 13. Other deaths over one year 130. Stillbirths 16. Total 216.

INDIANS — Tuberculosis 7, Influenza 3, Pneumonia (other forms) 3*. Other deaths under one year 2. Other deaths over one year 7. Stillbirths 2. Total 24*.

* Two whites on Indian Reserves included.

Measles are epidemic at present. Special care should be taken to prevent infants becoming infected as fatal results are more common in the younger age groups.

Typhoid Fever—Although not reported in this period, we may state that there was an epidemic of some twenty-five cases this spring in unorganized territory in the vicinity of Anama Bay. There is no resident physician in that area and as there were no known deaths, medical attention (and reporting) were not forthcoming until many cases had developed. Tracing of the original case was impossible but it is probable that a carrier or ambulatory case went into the area and spread the infection. We must be always on the watch for cases and carriers. Contacts of either should be vaccinated with Typhoid paratyphoid Vaccine **every year.**

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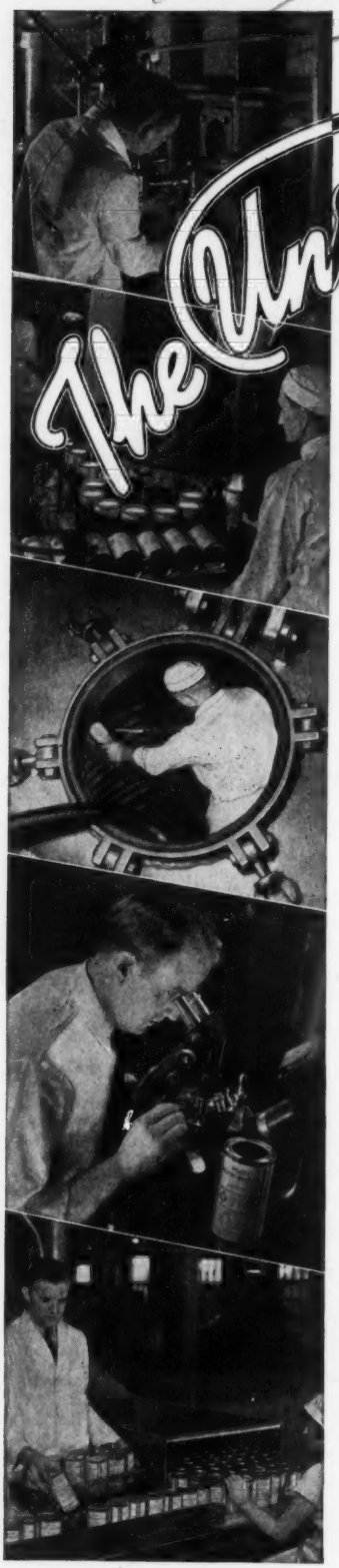

The Unseen Quality of DEXTRI-MALTOSE

DEXTRI-MALTOSE is no ordinary carbohydrate. Step by step, its manufacture is surrounded with every care and precaution, evolved through long years of experience and research.

Unseen by physician and patient are numerous safety factors, the practical effect of which nevertheless is present in every package of Dextri-Maltose. To name a few of these:

1. Dextri-Maltose is sampled for bacteriological testing before drying.
2. Steam at 20 pounds pressure sterilizes Dextri-Maltose filter presses which remove proteins, fat, and indigestible residue.
3. Blood agar tests are made to insure absence of hemolytic cocci.
4. Dextri-Maltose containers are paper-wrapped to prevent the cans from accumulating dust.
5. Bacteriological tests are made in a steam-washed plating room, the air of which is filtered.
6. Dextri-Maltose containers are automatically filled and closed without human handling of the product.
7. The direct microscopic test which Dextri-Maltrose receives is but one kind of 6 microbiological tests which it must routinely meet.
8. The interiors of the large converters in which Dextri-Maltose is processed are thoroughly scrubbed prior to steam sterilization.
9. Steaming under 20 pounds pressure sterilizes the converters for processing Dextri-Maltose.
10. After being packaged, Dextri-Maltose is held in storage and released only after final approval from the bacteriological checking laboratory.
11. Portable equipment used in manufacturing Dextri-Maltose is sterilized in autoclaves at 20 pounds live steam pressure for 20 minutes.
12. Dextri-Maltose is tested routinely to check the keeping quality of prepared feedings held in refrigeration for 24 hours.

It is, therefore, no mere coincidence that Dextri-Maltose enjoys greater paediatric acceptance today than ever before. By constant research and everlasting watchfulness, we try to keep pace with paediatric progress, and we put forth every human effort to merit the continued respect and confidence of the medical profession.

The True Measure of Economy Is Value

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